



CREE NON-INSURED HEALTH BENEFITS Reimbursement Claim Form

SECTION 1 CLAIMANT INFORMATION

NAME _____ JBNQA NO. _____

ADDRESS _____
STREET NAME, P.O. BOX COMMUNITY POSTAL CODE

TELEPHONE _____
HOME MOBILE WORK

EMAIL _____ DIRECT DEPOSIT ☐ INCLUDE VOID CHEQUE ☐
TRANSIT NO. _____ ACCT. NO. _____

SECTION 2 USER INFORMATION

NAME OF BENEFICIARY _____ JBNQA NO. _____

DATE OF BIRTH _____
YYYY-MM-DD

SECTION 3 TYPE OF BENEFIT

DESCRIPTION (VISION CARE, PRESCRIPTION DRUGS, MEDICAL SUPPLIES AND EQUIPMENT, DENTAL SERVICES) **AMOUNT CLAIM**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMPORTANT: FOR VISION CARE REIMBURSEMENT PLEASE ATTACH COPY OF THE PRESCRIPTION

SIGNATURE OF THE CLAIMANT _____ DATE _____

RESPONSIBLE FOR NIHB _____ DATE _____

NIHB DEPARTMENT USE ONLY

AUTHORIZATION NO. _____

SIGNATURE _____ DATE _____